TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Richard Lawrence, M.D.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-17-3195-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
June 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PROVIDER PUT ASIDE TIME FOR THIS NO-SHOW + HE HAD TO TRAVEL TO THE APPOINTMENT"

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The current fee schedules adopted by the Division of Workers' Compensation do not allow for any no-show fee based on the Claimant's failure to attend the evaluation. Consequently, the provider is not entitled to reimbursement for this billing, as no services were rendered."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2017	Designated Doctor No-Show Fee	$250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 provided the fee guidelines for medical and division-specific services provided from September 1, 2002, until March 1, 2008.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services provided from March 1, 2008, until September 1, 2016.
4. Texas Administrative Codes §§134.209 through 134.250 provide the fee guidelines for division-specific services provided on or after September 1, 2016.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.
   - TR03 – The billed service/procedure is not reimbursable under workers compensation.
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies. Use only if no other code is applicable.
   - W3 – Additional payment made on appeal/reconsideration.
   - Z001 – For explanation of a non-payment by the adjuster, please contact the adjuster on file.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

Richard Lawrence, M.D. is seeking reimbursement of $250.00 for a broken appointment for a designated doctor examination scheduled to occur on April 26, 2017. Travelers Indemnity Company (Travelers) denied the charges, in part, with claim adjustment reason code TR03 – "The billed service/procedure is not reimbursable under workers compensation." In its position statement, Travelers argued that "The current fee schedules adopted by the Division of Workers' Compensation do not allow for any no-show fee based on the Claimant's failure to attend the evaluation."

As explained in the preamble to 28 Texas Administrative Code §134.204, effective March 1, 2008, 33 TexReg 364, the reimbursement for missed appointments was removed from the medical fee guideline by adopted Texas Administrative Code §134.202 in 2002, in part, because the reimbursement structure for designated doctor examinations changed, which resulted in an overall increase in reimbursement for such examinations from the previous Texas Administrative Code §134.201. The overall increase in reimbursement factored in the no-show rate and was intended to compensate for possible costs a health care provider may incur due to missed appointments.

The current rules do not provide for reimbursement of missed appointments for designated doctor examinations based on the claimant's failure to attend the examination and documentation does not support the procedure code billed. The division concludes that the insurance carrier's denial of payment is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	July 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.